

6427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G262 5/11/60 iwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Rural</u>				c. LENGTH OF STAY IN 1b <u>X Rural - Berlin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.R.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Vance</u> Middle <u>Bayne</u> Last				4. DATE OF DEATH <u>May</u> Month <u>2</u> Day <u>1960</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25 1884</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Belmont Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cynacellan</u>		11. BIRTHPLACE (State or foreign country) <u>Greenford England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Vance Bayne</u>				14. MOTHER'S MAIDEN NAME <u>Anna McGuffee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MR. DELBERT TREMBLY</u> Address <u>WILMINGTON, DEL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420J</u> DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>None</u> DUE TO <u>None</u> (c) <u>None</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lived alone - Didn't use MD's</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>0</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N.E. Santorius Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N.E. Santorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR <u>May 9 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

TO DEDUCE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please enclose it with this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILTON Middle M. Last DALE		4. DATE OF DEATH Month May Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural mail carrier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Mail	
11. BIRTHPLACE (State or foreign country) Whaleyville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Dale		14. MOTHER'S MAIDEN NAME Jennie Mumford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XXX	
17. INFORMANT Herman Truitt		Address Whaleyville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease & Coronary Arteriosclerosis (c) Severely Dilated Anterior Interventricular Septum			INTERVAL BETWEEN ONSET AND DEATH minutes 5 yrs 12 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Left Ventricle & Bilateral Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan , 19 48 , to May 10 , 19 60 , that I last saw the deceased alive on May 10 , 19 60 , and that death occurred at 2 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Herman Truitt M.D. _____ PHYSICIAN'S NAME (Type) Berlin, M.D.			
22a. BURIAL, CREMATION, Cremation		22b. DATE THEREOF 05/14/60	
22c. NAME OF CEMETERY OR CREMATORY Silverbrook		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24a. REC'D BY REGISTRAR DATE MAY 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

Reg. No. 100

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		New York City		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		Jan 15, 1934		10:00 AM		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature		Burial Time		Burial Signature	
Jan 10, 1934		10:00 AM		New York City		Heart Disease		Natural		Catholic Cemetery		Jan 15, 1934		10:00 AM		J. Doe, M.D.		10:00 AM		J. Doe, M.D.	

CERTIFICATE OF DEATH

Reg. Dist. No.

06387

6425

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fletcher</u> First Middle Last		4. DATE OF DEATH <u>May 22, 1960</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1886</u> 74 yrs.
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dryden</u>		14. MOTHER'S MAIDEN NAME <u>Harriet ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-6659A</u>	
17. ADDRESS <u>Edna Dryden 7 Gray St Pocomoke City, Md.</u>		INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease, Severe</u> DUE TO <u>Arteriosclerosis & Atherosclerosis, Mod. Severe</u> (c) <u>many years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Prostatitis & Chronic Gastritis, Moderate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1949</u> to <u>23 April 1960</u> , that I last saw the deceased alive on <u>23 April 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. E. Sartorius, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pocomoke City, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius, Jr., M.D.</u>		<u>114 Market St., Pocomoke City, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 27, 1960</u>	<u>Hall's Hill Cem.</u>	<u>Pocomoke City, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, Va.</u> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>JUN 2 '60</u>	<u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6429

CERTIFICATE OF DEATH

06388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX				/d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First D. Middle Ryal Last Hudson				4. DATE OF DEATH Month May Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John T. Hudson				14. MOTHER'S MAIDEN NAME Martha Esham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XX		17. INFORMANT Mrs. Grace Hudson Bishop, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis & myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO Had a "heart attack" 1 week ago (treated) (c) By Dr. Robins, Baltimore, Md.							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Attended by Dr. Robins (see above) that I last saw the deceased alive on 19 and that death occurred at 10:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl B. McFadden M.D.				DATE SIGNED 20 May '60			
PHYSICIAN'S NAME (Type) Earl B. McFADDEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/60		22c. NAME OF CEMETERY OR CREMATORY I. O. O. F.		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Seligman, Del.				24a. REC'D BY REGISTRAR DATE MAY 24 '60		24b. REGISTRAR'S SIGNATURE Charles S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Date of Death: [illegible]
7. Time of Death: [illegible]
8. Cause of Death: [illegible]
9. Place of Death: [illegible]
10. Signature of Physician: [illegible]
11. Signature of Registrar: [illegible]
12. Date of Registration: [illegible]

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during the last illness.
2. The cause of death should be stated in full, and the immediate cause should be stated first.
3. The date of death should be stated in full.
4. The place of death should be stated in full.
5. The signature of the physician or other qualified person should be written in full.
6. The signature of the registrar should be written in full.
7. The date of registration should be written in full.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06389

Reg. Dist. No.

6423

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		0210.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hotel Commander</u>				d. STREET ADDRESS <u>23 State Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>C</u> Middle <u>Jameson</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1910</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sect.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel, Mgr</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Robert B. Fitzsimmons</u>				14. MOTHER'S MAIDEN NAME <u>Grace McFeaters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>880-24-0902</u>		17. INFORMANT Address <u>Mrs. Meredith L. Elder- Sister- Clairton, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Lovett</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Lovett</u>		DATE SIGNED <u>May 29 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any fee is necessary, please enclose it with this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Juror		12. Signature of Witness	
13. Signature of Physician		14. Signature of Nurse		15. Signature of Other	
16. Signature of Family		17. Signature of Friend		18. Signature of Other	
19. Signature of Other		20. Signature of Other		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
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58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other	
64. Signature of Other		65. Signature of Other		66. Signature of Other	
67. Signature of Other		68. Signature of Other		69. Signature of Other	
70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other	
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79. Signature of Other		80. Signature of Other		81. Signature of Other	
82. Signature of Other		83. Signature of Other		84. Signature of Other	
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94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

DO NOT WRITE IN THESE SPACES

1

6430

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06390

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 1b 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last JONES		4. DATE OF DEATH Month May Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1877
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Henry Clay Pilchard		14. MOTHER'S MAIDEN NAME Susan Jane Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cassius C. Jones, Stockton, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Oedema 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Degenerative Heart Disease DUE TO (c) 1 Hour INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension (b) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1959 to May 22, 1960 that I last saw the deceased alive on May 21, 1960 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stockton, Maryland DATE SIGNED 5/23/60			
ACTUAL SIGNATURE Charles W. Trader, M.D.			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market St., Pocomoke City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-24-60	
22c. NAME OF CEMETERY Gumby Presbyterian		22d. LOCATION (City, town, or county) (State) Stockton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Watson		24a. REC'D BY REGISTRAR DATE MAY 26 '60	
ADDRESS Pocomoke City, Md.		24b. REGISTRAR'S SIGNATURE C. L. S. H. H. H.	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARA KATHERINE MATTLAGE				4. DATE OF DEATH Month Day Year May 18 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1888	
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. BIRTHPLACE (State or foreign country) New York	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming			
13. FATHER'S NAME George Mattlage				14. MOTHER'S MAIDEN NAME Clara Spellmeyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Mrs Florence Turner, Redbank, New Jersey				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 57x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CARCINOMATOSIS DUE TO (c) PRIMARY CARCINOMA OF PANCREAS INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 6 MONS 18 MONS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/2, 1956 to 5/18, 1960, that I last saw the deceased alive on 5/17, 1960, and that death occurred at 2 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. D. Hamilton M.D. 212 MARKET ST. 5/18/60 PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON Pocomoke City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-20-60			
22c. NAME OF CEMETERY Presbyterian				22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Dutton				24a. REC'D BY REGISTRAR DATE MAY 23 '60			
24b. REGISTRAR'S SIGNATURE Charles S. Hume							

TO HOWARD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6424 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G264 6-6-60 et

66392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> 46X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>7 Palmyr Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Michael Francis O'Neill</u>		4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 - 1918</u>
9. AGE (Indicate for birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Insurance + Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Walden, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John O'Neill</u>		14. MOTHER'S MAIDEN NAME <u>Rose Floyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>42-07-050</u>	
17. INFORMATION <u>Wilmington</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute coronary occlusion (Probably)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute coronary occlusion (Probably)</u> DUE TO (c) <u>Acute coronary occlusion (Probably)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>June 1st - All Saints Cemetery</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington Del</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Bumbago Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. H. H.</u>	

MEDICAL CERTIFICATION

2

TO DIE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a preliminary certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6426

CERTIFICATE OF DEATH

06393
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS R.F.D. # 2 Box 421	
3. NAME OF DECEASED (Type or print) Williams Edward Wise		4. DATE OF DEATH Month May Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Williams Edward Wise, Sr.		14. MOTHER'S MAIDEN NAME Grace Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-12-0964A	
17. INFORMANT Mrs. Beulah Hughes		Address 106 W. Sharpneck ST. Philadelphia, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c) Glomerulonephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-8 , 19 60 , to 5-9 , 19 60 , that I last saw the deceased alive on 5-9 , 19 60 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md	
DATE SIGNED 5/13/60			
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.		Berlin Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5, 15/60	
22c. NAME OF CEMETERY OR CREMATORY Wardtown, Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton		ADDRESS New Church, Va.	
24a. REC'D BY REGISTRAR MAY 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF THE

COMMISSIONER OF

THE

STATE OF

NEW YORK

FOR THE YEAR

ENDING

DECEMBER 31,

1938

ALBANY:

THE

UNIVERSITY OF THE STATE OF NEW YORK

1939

ALBANY:

THE

UNIVERSITY OF THE STATE OF NEW YORK

1939

ALBANY:

THE

UNIVERSITY OF THE STATE OF NEW YORK

1939

ALBANY: